Washington State Department of Social & Health Services

DIVISION OF DEVELOPMENTAL DISABILITIES

PLAN OF CARE

☐ Initial Plan ☐ Basic ☐ Annual Plan ☐ Basic Plus ☐ Core ☐ Community Protection

SECTION ONE - PERSONAL DATA

It is very important to verify that all information in this section is current and correct.

If any of the information has changed, be sure to enter the correct information into the CCDB immediately!

Make sure to identify a contact in case of natural disaster or service-related emergency.

NAME		DATE OF BIRTH
ADDRESS		
TELEPHONE NUMBER	CSO NUMBER	DDD NUMBER
SIGNIFICANT OTHER	RELATIONSHIP	TELEPHONE NUMBER
☐ Parent/Family Member ☐ Guardian ☐ Advocate ☐ Other: (Describe)		
EMERGENCY CONTACT NAME	RELATIONSHIP	TELEPHONE NUMBER
CASE MANAGER		TELEPHONE NUMBER
DATE OF PLANNING MEETING	**PLAN EFFECTIVE DATE**	

Every effort must be made to include the people in the plan development process that the waiver participant would like.

Attended Meeting:

NAME	RELATIONSHIP TO WAIVER PARTICIPANT	NAME	RELATIONSHIP TO WAIVER PARTICIPANT

Note everyone who attended the meeting and/or contributed to the plan. All adult participants **MUST** attend the meeting.

Contributed to plan but did not attend meeting:

NAME	RELATIONSHIP TO WAIVER PARTICIPANT	NAME	RELATIONSHIP TO WAIVER PARTICIPANT

A Support Needs Assessment must be completed and ICF/MR eligibility confirmed prior to completing the POC.
A complete waiver plan for participants with personal care services will be a combination of this POC and the CARE instrument. If any information in this plan is already documented on the CARE instrument, write, "CARE" on the line or across the section. If some information is found on the CARE instrument but you need to add more here write "CARE" plus . . ." and then write in the additional information.

NAME:	DDD NUMBER:

Please provide a brief description of the waiver participant and their current situation.

The idea is, (in a very brief way), to have a sense of this person, what their life looks like, what's going on in the life, highlights and major issues. etc.

Personal "Snapshot"

SECTION TWO - HEALTH INFORMATION

Remember!
Get the dates.
Every effort must be made to get the actual date, but if the person/family cannot provide the exact date you must at least indicate the month.

Because routine dental and medical visits are so important to staying in the best of health, be sure there is a discussion explaining the reasons/benefits.

Offer assistance to connect with a doctor or dentist if needed.

Medical

Primary Physician

Name: _____

Telephone Number: _____

Date of Last Physical: _____

Status of ongoing health issues:

New Concerns:

If, after a discussion of the importance of yearly physicals the person/family/ guardian refuses a physical, have them initial here: _____

Dental

Dentist

Name: _____

Telephone Number: _____

Date of Last Dental Exam: _____

Status of ongoing issues:

If, after a discussion, the person/family/guardian chooses to see a dentist only one time yearly, have them initial here: _____

If, after a discussion of the importance of yearly dental visits, the person/family/guardian refuses a dentist, have them initial here: _____

Other health services can include any sort of medical providers or therapist.

Other Health Services
(Additional Physicians, Behavior Mgmt., OT, PT, etc.)

Name: _____

Type: _____

Status of ongoing issues:

Name: _____

Type: _____

Status of ongoing issues:

NAME:	DDD NUMBER:

This is very important information and an opportunity to make sure that proper medication management is happening for this person. You may attach available listing of medications, dosage, etc.

Medication Management:

Please list the medications you currently take and what they are for:

Who prescribes them and how often are they reviewed?

Do you need any help taking your medications? Please describe:

Do you have any concerns about your medication?

SECTION THREE - CURRENT SUPPORTS & RESOURCES

The information in Section Three is useful to better understand a person's supports and resources, as you work to put together a plan to meet their health and welfare needs.

Current Living Situation: Identify what type of residential setting such as parent home, own home, AFH, etc.

Own home = person pays rent and it's not the family home.

Note who else lives with the person and their relationship.

Note any residential supports provided.

CURRENT LIVING SITUATION

OTHER SERVICES UTILIZED (NOT FUNDED BY DDD) (DVR, MH, SUBSTANCE ABUSE, SCHOOL SERVICES, ETC.)

DAY PROGRAM PROVIDER	DAY PROGRAM TYPE
MEDICARE	OTHER MEDICAL INSURANCE (SPECIFY)

These dollar figures are based on client report at the time of the planning meeting.

Monthly Benefits and Income

- ☐ Basic Food $ _____
- ☐ Section 8 Rental Assistance $ _____

Monthly Total $ _____

- ☐ SSP $ _____
- ☐ Wages $ _____
- ☐ Other sources of income $ _____

SSA/SSDI/DAC $ _____

SSI $ _____

Monthly Total $ _____

NAME:	DDD NUMBER:

SECTION FOUR - DETERMINING HEALTH AND WELFARE NEEDS

Review of Current Plan

If this is an initial plan this section does not have to be completed.

If this is an annual review, facilitate a discussion looking at how the current plan is working, what is working well and should continue, changes that need to be made and any new issues to be addressed.

The waiver participant, their family/legal representative and any current providers need to be asked these questions.

Which services and supports are meeting the individual's needs? Should they be continued? Are changes needed?

Which services and supports are not adequately meeting the individual's needs, requiring some changes?

Are there new needs to be addressed?

Are there any issues relating to finding/maintaining a provider?

If the individual has other services plans, IEP, 504 Plan, IFSP, DVR, etc. review and include any additional needs information identified.

NAME:	DDD NUMBER:

It is vital to find out what the person and/or their family/guardian, feel is needed to meet the waiver participant's health and welfare needs. This box should contain only items in addition to those already identified above.	Any other Health and Welfare Concerns identified by the person/family/guardian and not captured to this point.

STOP

The team must discuss all the needs identified and agree which are necessary to ensure the waiver participant's health and welfare. Those must be addressed by this plan. If there are unmet health and welfare needs that will not be addressed by this plan, document the reason why below.

Next discuss services and supports that might meet the agreed upon needs. This discussion must include ideas about unpaid as well as paid supports; state plan services as well as waiver services. Every waiver participant MUST be offered choice of qualified waiver providers. If a person has a current provider they are not happy with, the issue must be addressed and a plan of action arrived at that all are comfortable with.

Once the team feels they have a good idea of how to best meet the agreed upon needs, go on to document the steps necessary to put the plan in place.

Explanation of any health and welfare needs that will not be addressed in this plan:

NAME:	DDD NUMBER:

SECTION FIVE - A PLAN FOR MEETING AGREED UPON HEALTH AND WELFARE NEEDS

Needs Assessment Number ______________________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

Needs Assessment Number ______________________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

Needs Assessment Number ______________________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

NAME:	DDD NUMBER:

Needs Assessment Number ______________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

Needs Assessment Number ______________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

Needs Assessment Number ______________________

What steps must be taken and/or what services/supports need to be in place to meet this need?	Provider/ Responsible person?	Check if Waiver Funded Service	Frequency? Daily/Wkly/Mthly Quantity: Hrs/Days/Mths	If new, what is the start date?	Prior approval received if needed

NAME:	DDD NUMBER:

SECTION SIX - WRAP-UP AND SIGNATURES

Review/monitoring activities must be documented in the Service Episode Record (SER)

Plan Review

Once the plan for meeting health and welfare needs is completed a decision must be made as to the required frequency for monitoring of the plan. This decision is to be made based on the complexity of the plan and the fragility of the person and/or their supports. Check the appropriate box below:

This plan will be reviewed: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

It is very important to have a discussion about the items, before asking the person to check them.

NOTE: Individuals must be given their appeal rights in writing every time there is a change in their plan.

Please check the items below to indicate that they occurred. The plan will not be finalized until the client/legal representative has checked all the boxes. C= Client, L= Legal Representative.

C	L	
☐	☐	I received information regarding waiver services and providers I needed to complete the plan.
☐	☐	I had a choice of qualified providers to meet my health and welfare needs.
☐	☐	If any current provider is not to my satisfaction, I was able to plan to meet my needs in other ways.
☐	☐	My health and welfare needs are either currently being met or an adequate plan is in place to meet them in a timely manner.
☐	☐	Any issues or concerns I brought up related to this plan of care have been/are being addressed.
☐	☐	I have been treated with respect by my providers.
☐	☐	I know I can request a review of this plan at any time.
☐	☐	My rights to appeal the decisions made by the Division of Developmental Disabilities have been explained to me. The procedures for making an appeal have been explained to me.

Signatures and dates are required for plan implementation.

As per WAC 388-845-3020 consent is assumed after 30 days unless otherwise indicated by the waiver participant/legal representative.

Make sure the choice regarding agreement is indicated.

The CRM is the last one to sign. **This becomes the plan effective date. Please go to the front page of the plan and record that date.**

I have participated in the development of and/or reviewed this individual plan of care and **AGREE** to the services and supports described.

Waiver Participant: _____ Date: _____

Legal Representative: _____ Date: _____

Case/Resource Manager: _____ Date: _____

I have participated in the development of and/or reviewed this individual plan of care and **DO NOT AGREE** to the services and supports as described. I have been given my appeal rights. I understand that if I do not sign the plan and have not requested an appeal within 28 days, consent will be assumed and the plan implemented as written.

Waiver Participant: _____ Date: _____

Legal Representative: _____ Date: _____

Washington State Department of Social & Health Services

DDD INDIVIDUAL PLAN OF CARE REQUEST FOR APPEAL HEARING

per Chapter 388-02 for DSHS fair hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME	TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARINGS (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following decision by the Department of Social and Health Services (DSHS):

- Explain briefly what DSHS did or did not do (add pages if you need more room); and
- Attach a copy of the notice you are appealing, if possible.

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ MESSAGE PHONE

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ Yes ☐ No Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER

ADDRESS STREET CITY STATE ZIP CODE

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ Yes ☐ No

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.

Washington State Department of Social & Health Services

DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES

PLAN OF CARE MEETING SURVEY

TO BE COMPLETED BY DDD STAFF
POC MEETING DATE
WAIVER: ☐ Basic ☐ Core ☐ Basic Plus ☐ Community Protection

This survey is voluntary and confidential. Your services will not be affected by your choice to participate or not to participate. This survey will help us improve the Plan of Care process.

What is your relationship to the person receiving services?

☐ I am the person receiving services. ☐ Family Member/Guardian ☐ Paid Staff ☐ Friend/Advocate

SURVEY

NO.	QUESTION	(1) YES	(2) NOT SURE	(3) NO
1.	During the plan of care process, was your Case Manager respectful and courteous?			
2.	Did your Case Manager ask if you had any concerns about your current services?			
3.	Were your concerns discussed and included in the planning process?			
4.	Did you help develop your new Plan of Care?			
5.	Did you receive information about what services are available in your waiver to meet your assessed needs?			
6.	Were you given a choice of services that are available in your waiver to meet your assessed needs?			
7.	Were you given a choice of service providers?			
8.	Did you plan to meet your needs and goals for both waiver and non-waiver services?			
9.	Were your health and safety needs discussed?			
10.	Were plans made to meet your health and safety needs?			
11.	Did you plan for emergencies, such as an earthquake or if your regular provider is unavailable?			
12.	Did you receive information on what to do if your needs change before the next annual planning meeting?			
13.	Did you receive information on how to make a complaint or ask for a fair hearing?			

14. Please use the space below to provide additional comments; or to tell us what suggestions you have to improve the Plan of Care process.

DSHS 15-272 (01/2005)

Please return using the enclosed stamped, addressed envelope, or mail to:

Department of Social and Health Services
Division of Developmental Disabilities (DDD)
Attention: Quality Assurance
PO Box 45310
Olympia WA 98504-5310